Health Homes Webinar Series:
Program Manual and Documents List
Questions & Answers
February 25, 2014

Q: What is a 'panel'? (This was discussed in section discussing Lead Entity Contracts with Health Home Partners.)
A: This is a term often used by Primary Care Providers to describe the total number of patients served or the number of patients served within a certain category (i.e. Medcaid, Medicare, Blue Cross, etc.)

Q: In completing the tool, should we answer the questions based on our current clients, the projection of those eligible in our area, or the minimum number we believe the PMPM (“Per member/Per month”) will support?
A: It is appropriate to include all three. The MCOs will want to know what you can currently support and what your future capacity will be. However, in order to be fiscally responsible for your agency, you will want to consider what the payment will support as well.

Q: Is it accurate to state that a HHP could be a sole source provider in terms of limiting their "panel" to only the individuals that they currently serve?
A: That is a possibility. However, if you serve a small number of consumers, it may be unlikely that the Lead Entity would be interested in contracting with you because we’re requiring them to have a statewide network and to be able to serve, essentially, maximum 75,000 people between the two populations. But, I do know that the MCOs are not…are not completely averse to working with providers who want to serve a particular population.

Q: On page 17 of the presentation, where do the CMHC's fall?
A: Community Mental Health Centers are on the list as a potential Health Home Partner.

Q: Please clarify HH eligibility for KanCare members with dual mental health and substance use disorders. Does it matter which diagnosis is considered "primary?"
A: No. So, there will be people who will have both diagnoses and for those diagnoses, it doesn’t matter whether the SMI diagnosis is first or second.

Q: Also, if member qualifies for both SMI and CC health home on 7/1, which one will be the default enrollment?
A: MCOs will make their assignments based on the data that they have and using that data to determine what they think is the most appropriate assignment. However, the member has the right to choose the different Health Homes.

Q: Do we have specific diagnoses that will be served with the chronic health conditions plan?
A: Yes. The Chronic Conditions SPA includes people who have asthma or diabetes, AND are at risk for one of several other chronic conditions. For additional information, please visit this link: http://www.kancare.ks.gov/health_home/providers_materials.htm

Q: Will the Lead Entities be reaching out to providers already in their network to serve as HHP or is the responsibility on the location who might want to be a HHP?
A: Lead Entities have been having some discussions with some providers in their networks. And, in some cases, they reached out and in other cases, it was the provider. You are encouraged to reach out to the MCO directly. While receipt of a Preparedness and Planning Tool will trigger interaction with the MCO, feel free to contact your provider representative or anyone else at the MCO that you're used to working with, and let them know that you're interested and they'll share that information within their agency.

Q: Will subcontracting role options be fully explained in the Manual?
A: No. With the exception of limited information about the special relationship between Health Homes Providers and Targeted Case Management Providers for people with I/DD and payment information; this manual is intended to outline specifics between the Lead Entity and the Health Home Partner, not between the Health Home Partner and their subcontractors.

Q: When will MCO's be required to share their expectations of HH partners? (i.e. specific assessment tools to be used, etc.)
A: *(United Healthcare response):* We are still working to resolve a couple questions surrounding some of the reporting and some of the NCQA implications for some of that reporting and oversight. Therefore, there may be some additional information coming on that. The MCOs do have solutions and resources to offer related to Health Information Technology. However, we are not anticipating many additional requirements beyond what's been outlined in the Preparedness and Planning Tool.

(Amerigroup response): The majority of the required paperwork is going to be provided on the State website and we would encourage people to always refer back to the KanCare Health Homes website for any required paperwork or forms. The information and function around Health Homes is going to be very similar across all MCOs and we all have Health Information Technology resources available to help facilitate all of those activities.

Q: Can members choose between Health Homes if they don't have a diagnosis or qualification for both? Such as, a member with a chronic condition and no SMI, could they choose to be in the SMI Health Home?
A: No. The member must meet the target population definition for the specific Health Home. They can, however, choose between different Health Home Partners within the Chronic Condition Health Homes.

Q: Where can we access contact information for the MCOs?
A: This information will be located in Appendix A of the Program Manual when it is complete. Each PowerPoint presentation for the webinars also includes contact information for each MCO.

Q: Is April 1 still the date for submission of the Planning Tool? The pay structure is not presented as a webinar until 3/25.
A: Yes, April 1 is still the date for submission of the Preparedness and Planning Tool.

Q: Are any of the MCOs planning to provide any of the six core services themselves or can the partner provide all six?
A: *(United Healthcare response):* There are some 'core business functions' that we are going to always hold on to. For example, health risk assessments. However, we do envision that some Health Home Partners will be able to do all six.

(Amerigroup response): All the of the MCOs agree that there are three core services that Health Home Partners should be prepared to deliver. However, it is more focused on partnership between the Lead Entity and the Health Home Partner. It's really much more important to understand that if a Health Home Partner is unable to provide one of the services, the Lead Entity should and would be able to help provide those services.

Q: Can a CMHC be a Chronic Conditions Health Home? That is, serve a person with a chronic health condition, but who has no SMI diagnosis?
A: Potentially, yes. If they can meet the requirements on the Chronic Conditions side and they would have the professionals available that are spelled out in that SPA, presumably they could become a Health Home Partner for both types of SPAs.

<u>Questions not addressed in this webinar</u>

Q: Has there been clarification on how children in foster care placements will be assigned to SMI Health Home partners?
A: Assignments will be made based on the data the MCOs have available, looking at the member's service utilization and what providers they are already seeing, as well as what Health Home Partners are available in the member's area. There are some special processes related to the choices HH members who are also in foster care have. These are outlined in Section 4.3 of the SMI Health Homes Program Manual.

Q: Do the MCO's get paid the total PM/PM, regardless of whether the services are provided or not? If so, do the HHP only get paid the PM/PM, if the service is provided?
A: No. Either the MCO or the HHP must provide a service in the month in order to trigger the PMPM from the state to the MCO.

Q: Will the MCOs have standard forms, and reporting system?
A: There are several forms developed by the state that all three MCOs and HHPs will use. Reporting information will be outlined soon. Each MCO will use their own data

portal to share information which they have with HHPs since these are part of their larger, proprietary information systems.

Q: If all health home services are billed under the same S0281 code, how will we know what rate to enter into our systems for each client under this code?
A: The rates are a per member per month (PMPM) single rate for any and all Health Home services, so providing one or six services, results in the same PMPM paid to the MCO, who will pay the HHP in the same manner. The MCO will inform the HHP what level each member is in in order for the HHP to bill at the correct level.

Q: If the Lead Entity and HHP are both paid on a PMPM, how do you anticipate a supporting provider being paid? Are supporting providers still going to be used to deliver some for the health home services?
A: Any provider who sub-contracts with the HHP, would most likely be paid by the HHP and how that payment arrangement is made, with the exception of I/DD TCM providers, would be worked out between the HHP and subcontracting provider.